Trustee Insights
PRACTICAL GOVERNANCE

Governance Leadership of Quality: Confronting Realities and Creating Tension for Change

A self-assessment tool can help health care boards address barriers to effective quality oversight

BY JIM CONWAY

Leadership of quality is a key responsibility of governance and, done well, serves as an exceptional gift: engaged boards produce better outcomes. For all the progress made over the last 20 years, however, many boards, trustees, and executives continue to struggle with quality oversight.

The board, board chair, and CEO, together, must ensure that their vision, strategy, and goals are strong and aligned. Further, they must confront the realities of current practices, specifically those that are impeding achievement.

Use of a "Governance Quality Engagement Diagnostic" (a tool introduced below), along with a careful approach to organization assessment, can identify barriers to effective board quality oversight and help drive understanding, learning, and continuous improvement.

Issues and Implications

Over the last 20 years, the health care field has been on a quality journey, including a strong and constantly renewing focus on the engagement of governance to achieve quality outcomes and care that is safe, effective, patient-centered, timely, efficient, and equitable. Bold aims have been set at

TRUSTEE TALKING POINTS

- The evidence grows that engaged boards produce better quality outcomes.
- Yet many boards and executives struggle with quality and safety oversight.
- Outmoded board structures, processes, and outcomes can impede achievement.
- Tools, frameworks, and guides are available to foster continuous improvement.

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national, system, and entity levels. Extensive contributions to improve practice have come from individuals, health care organizations, regulatory and accrediting organizations, research, literature, and continuing education.

Much has been achieved via this broad emphasis and engagement across the field. Self-assessment tools, frameworks, and guides are available so that organizations can assess how they measure up against best practices. The evidence grows that engaged boards produce better outcomes.

In 2017, the Joint Commission issued Sentinel Event Alert #57, affirming the essential role of leadership, and specifically governance, in developing a safety culture. Yet struggles, problems, and challenges with board engagement exist at many hospitals and health systems and, for some, they grow.

Many trustees and executives remain frustrated with outmoded board structures, processes, and outcomes. It is not unusual to walk into a boardroom and find trustees and leaders dealing with many of the same barriers they struggled with five, 10, or 20 years ago. For all we have accomplished to improve quality – and we have done a lot – there is much more to do for those we partner with and serve: patients, families, the public, health care organization staff, and communities.

In his book *The Fifth Discipline* (1990), Peter Senge introduced the powerful concept of "creative tension." He noted that leadership in a learning organization begins with creative tension, which comes from clearly seeing where we want to be (our vision), and telling the truth about where we are (our current reality). The gap between the two generates a natural tension. Creative tension can be resolved in two basic ways: by raising current reality toward the vision, or by lowering the vision toward current reality.

Individuals, groups, and organizations who learn how to work with creative tension understand how to use the energy it generates to move their realities more reliably toward their visions. Similarly, Carl Weick and Kathleen Sutcliffe, in their 2001 book *Managing the Unexpected*, encouraged developing a preoccupation with failure, now the first principle for High Reliability Organizations (HROs). This principle stresses the need for continuous attention to anomalies that could be symptoms of larger problems in a system. When people look for failures, they acknowledge the existence of incomplete knowledge.

Over the last 20 years, as an executive, improvement adviser, trustee, graduate school teacher, and patient and family member, I have come to believe that we must utilize more effectively the power of creative tension and a preoccupation with failure as we assess and confront more directly the struggles and problems many boards and leaders face in optimizing their processes and achieving better outcomes. The first step in the journey to higher quality is to understand the current reality and the challenges it presents.

A Diagnostic Tool

The Governance Quality Engagement Diagnostic on page four of this article is a self-assessment tool that can help health care boards and leaders highlight barriers and challenges to effective board engagement in quality oversight. The tool framework is constructed around six key drivers of engagement as reported initially in the 2006 "Getting Boards on Board" initiative of the Institute for Healthcare

Additional Resources

Leading a Culture of Safety: A Blueprint for Success (2017). American College of Healthcare Executives and National Patient Safety Foundation. Retrieved from http://www.npsf.org/page/cultureofsafety

Eliminating Harm, Improving Patient Care: A Trustee Guide (2018 Update). American Hospital Association. Retrieved from: http://www.hret-hiin.org/resources/display/eliminating-harm-improving-patient-care-a-trustee-guide

Getting the Board on Board: What Your Board Needs to Know About Quality and Patient Safety (3rd edition, 2016). Joint Commission Resources. Retrieved from: https://www.jcrinc.com/getting-the-board-on-board-what-your-board-needs-to-know-about-quality-and-patient-safety-third-edition/

"Tuning Up Health System Boards for Patient Safety" (audio program, 2017). Institute for Healthcare Improvement. Retrieved from: http://www.ihi.org/resources/Pages/AudioandVideo/WIHI-Tuning-Up-Healt-System-Boards-for-Patient-Safety.aspx

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Improvement (IHI): set aims; get data and hear stories; establish and monitor system-level metrics; change the environment, policies, and culture; learn from others and from each other; and establish executive accountability.

Organized within these key drivers are more than 60 challenges identified over the last 20 years from my own teaching engagements, consultations, site visits, and personal experiences as a trustee, as well as those reported by colleagues and in the literature. The tool was vetted with, and revised after, input from leaders with expertise in governance and quality. Testing the diagnostic in conference and classroom settings with trustees and health care executives indicated that people found considerable resonance with the tool's content, which, in turn, triggered significant discussions. The Governance Quality Engagement Diagnostic also can be downloaded here.

Challenges and Opportunities

Effective use of this tool is highly dependent on the board's culture. Before employing this diagnostic, boards should answer questions such as:

- Is this organization a safe place to speak up?
- Do people believe assessment findings will be used to drive change and improvement?
- Is it worth our taking the risk?
- Do we use a systematic model for improvement?

Using the tool can provide an opportunity to enhance the board's culture. For trustees and leaders frustrated over board practices, identifying and fixing barriers and challenges will help them participate in driving engagement forward: it is what matters to them. They are personally invested in positioning the board and organization for success.

Using the Diagnostic Tool

Employing IHI's Model for Improvement or a similar systematic approach, trustees and executives must commit to use the results and learning from the tool to drive change and improvement. Results must be compiled and presented to the board, as well as discussed and prioritized. Action plans then can be developed to drive improvement. During the process, organizations can seek out key resources, examples of best practices, and lessons learned by boards and associations leading the way to better outcomes. Many boards are already turning obstacles identified through the assessment into significant opportunities for continuous improvement.

TRUSTEE TAKEAWAYS

- Leadership of quality is a key responsibility of governance in health care.
- The board and CEO must work together to align vision, strategy, and goals.
- They must also reexamine practices to identify barriers to effective oversight.
- A Governance Quality Engagement Diagnostic can be an effective learning tool.

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Governance Quality Engagement Diagnostic

Overview

This diagnostic is designed to help boards and organization leaders identify challenges that may be impeding efforts to improve quality. Developed by Jim Conway, this resource draws on 20 years of personal governance experience as well as learning from the literature and the shared experience of trustees, executives, patients, family members, staff, teachers, and students. The tool framework is constructed around six key drivers of engagement as reported initially in the 2006 "Getting Boards on Board" initiative of the Institute for Healthcare Improvement (IHI). It identifies more than 60 challenges that, when addressed, can help boards and leaders create their own pathway to continuous improvement. The tool reflects quality domains identified by the National Academy of Medicine (formerly the Institute of Medicine), which include care that is safe, effective, patient-centered, timely, efficient, and equitable.

How to Use This Tool

Using this tool together (governance and leadership, including medical staff leadership):

- Check for evidence of problems and struggles that could be limiting impact
- Discuss why
- Seek out key resources, examples of best practice, and lessons learned by boards who are "leading the way"
- Develop a plan to address problems and turn them into opportunities for improvement
- Execute following the IHI's Model for Improvement [http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx] or a similar systematic approach

"Boards on Board" Drivers	✓	Board Leadership Barriers (CHECK ALL THAT APPLY)
1. Set aims	❏	1. "Pile it on" strategy; too many aims and priorities set
	❏	2. Lack of urgency/constancy of purpose; looking for "shiny new object"
	❏	3. Aims externally driven; missing internal "losing sleep" issues
	❏	4. External benchmarks set around the mean
	❏	5. No process for selecting and aligning aims against the triple/quadruple aim
	❏	6. "Favorites" get projects resourced; no transparency to justify choices and tradeoffs
	❏	7. Board fails to communicate what's important and why; goals not made public
	❏	8. Lack of will or vision of what is possible; status quo is fine
	❏	9. Failure to consider multiyear targets and timelines where appropriate
	❏	10. Overarching systemwide aims not set and/or achieved in multientity systems

Governance Quality Engagement Diagnostic

"Boards on Board" Drivers	✓	Board Leadership Barriers (CHECK ALL THAT APPLY)
2. Get data and hear stories	❑	11. Data and PowerPoint overload with no time for discussion
	❑	12. Patient and staff harm not discussed in the boardroom
	❑	13. Absence of guidelines on time allocated to presentations and discussion
	❑	14. Reports of the same types of errors over and over without improvement
	❑	15. Patient stories shared without discussion of impact or next steps
	❑	16. Data presented in red/yellow/green form and not data over time (run charts)
	❑	17. Same few trustee voices heard in board quality discussions
	❑	18. Lots of opportunities missed; hiding in 8-point font
3. Establish and monitor system-level metrics	❑	19. Stretch goals avoided to stay personally "safe"; courage not visible
	❑	20. Rate-based data, acronyms, and other abbreviations not understood by all trustees
	❑	21. Gaps between bold aims and current realities are not highlighted
	❑	22. Quality domains not in balance (e.g., no focus on equity, timeliness, etc.)
	❑	23. Interconnections among clinical, financial, service, and experience outcomes ignored, leading to unintended consequences
	❑	24. No clarity that the board's focus is on quality assurance and not quality control
	❑	25. Lack of knowledge on the cost implications of current quality performance
	❑	26. Aims chosen are inpatient focused and not reflective of the organization's breadth
	❑	27. Unit variation persists unchallenged; hidden under a "big dot" that is "OK"
	❑	28. Not enough use of leading indicators; performance data is routinely old

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Governance Quality Engagement Diagnostic

"Boards on Board" Drivers	✓	Board Leadership Barriers (CHECK ALL THAT APPLY)
4. Change the environment, policies, and culture	❏	29. "Core values light," with values not publicly verifiable every day
	❏	30. Quality isn't core to the organization values, principles, business strategy
	❏	31. Board hasn't publicly acknowledged its ultimate accountability for care quality
	❏	32. Trustees who have core competencies in quality are not sought out
	❏	33. Clinicians (M.D., R.N., etc.) have a limited role in board meetings
	❏	34. Patients and family advisers not at board quality table
	❏	35. Practices "only invented here"; little, if any, best-practice sharing or learning
	❏	36. Little recognition of, and celebration for, progress
	❏	37. Staff suffer from "projectitis" and drown under project "waterfalls"
	❏	38. Financial issues pushing quality off board agenda
	❏	39. Trustees/leaders speak about quality only when spoken to at board meetings
	❏	40. There are physicians on staff to whom you wouldn't refer family/friends
	❏	41. Credentials recommendations routinely approved by board without discussion
	❏	42. Quality is not represented at every board and committee table
	❏	43. Trustees' competencies and passions untapped
	❏	44. Board and trustees' self-assessments not conducted and/or not criteria-based
	❏	45. Trustees not helped to see what they should see
	❏	46. Board out of the loop in oversight of serious patient and staff harm
	❏	47. Leaders struggle with transparency and only positive outcomes are reported
	❏	48. Board follow-up loops routinely not closed
	❏	49. Board finds it difficult to do the work with 2 to 4 board quality meetings a year

Governance Quality Engagement Diagnostic

"Boards on Board" Drivers	✓	Board Leadership Barriers (CHECK ALL THAT APPLY)
5. Learn from others and from each other	❑	50. Board quality role not well understood by trustees or key stakeholders
	❑	51. No one's asking "Could it happen here?" when a serious event occurs elsewhere
	❑	52. Evaluations of board meetings are not conducted
	❑	53. Trustees never go to where the work is done (i.e., rounding in units and clinics)
	❑	54. Staff perceives trustees and leaders don't have a "clue" of work at the front line
	❑	55. No ongoing board orientation, continuing education, and/or coaching
	❑	56. Trustees not trained or assessed for knowledge about quality improvement and their role
6. Establish executive accountability	❑	57. Lack of clarity in governance/management roles and responsibilities
	❑	58. Lack of sustained leadership engagement over time
	❑	59. Absence of partnership among the board, chair, and CEO
	❑	60. Targets set without probing resource capacity to execute
	❑	61. Theory of work ahead unclear: What are key drivers? What is the evidence?
	❑	62. No succession planning to ensure continuous function of quality committee and board role in quality oversight
	❑	63. Trustees and leaders haunted by question: "If you knew, why didn't you do?"

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